Human Services Committee
Raised Bill No. 5500
An Act Concerning Provider Audits Under The Medicaid Program

Senator Slossberg, Representative Abercrombie and the Members of the Human Services Committee

My name is Edward Schreiner. I am a resident of 36 Pineridge Drive, Oakville, Ct. As a registered pharmacist, I have owned and operated Stoll's Pharmacy in Waterbury, Ct since 1988. I am also the Chairman of the Board of Directors for Northeast Pharmacy Service Corporation, a group purchasing organization (GPO) with approximately 275 participating community pharmacies throughout New England including 105 independent pharmacies in Connecticut.

I would like to thank the Human Services Committee for raising Bill No. 5500: An Act Concerning Provider Audits Under the Medicaid Program and for conducting this public hearing today.

Provider audits conducted by the State of Connecticut Department of Social Services were originally intended to detect and deter fraud, waste and abuse involved with the Medicaid drug program. I fully agree with the DSS Medicaid Program's mandate to root out fraud, waste and abuse; however I think that it is important that auditing activities serve to deter and eliminate fraud, waste and abuse rather than severely penalize providers that have acted in good faith when providing services to Medicaid recipients. The manner in which Medicaid audits are currently being conducted and the business-crippling recoupments being taken by DSS audit activities appears to be more of an administrative mechanism to help fund the Medicaid budget rather than any effort to ensure appropriate payments to providers for medically necessary services.

When fraud, waste and abuse can be ruled out as motivating factors, fairness dictates that minor clerical errors should be adjusted on a claim specific basis without penalty. In fact CMS requires that claims be corrected, not recouped or used to extrapolate further monetary recoveries from pharmacy providers under Medicare Part D program rules. Considering that federal funding is a large part of the Medicaid program I cannot understand why this rule does not apply to DSS Medicaid audits as well.

I believe that the extrapolation process currently being used during Medicaid audits is extremely unfair and causes huge financial burdens for providers. By applying extrapolation over the entire universe of claims encompassed by the audit sample time frame, the Department of Social Service is pursuing excessive punitive recoupment for minor technical discrepancies where no intent of provider fraud is evident. Sec. 17b-99 (2) of the Connecticut General Statues states that "any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit, shall not of itself constitute a wilful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established". Despite this regulation auditors frequently cite the Provider Agreement requirement to "adhere to all applicable state statutes and regulations promulgated by the Department" when issuing their findings. Using this justification pharmacies are frequently subject to recoupment of claim payments due to clerical, computer, or recordkeeping errors that have nothing to do with fraud and did not result in significant financial harm to the Medicaid program.

As the owner of Stoll's Pharmacy, I have experienced Medicaid audits on more than one occasion and found it to be a very stressful and intimidating process. At the exit interview from my most recent Medicaid pharmacy audit, I was told that no drug errors were found and that all changes we made to prescriptions were well documented and appropriate. One of the auditors requested that I pass along her compliments to my staff on the very clear documentation she found in our audited prescriptions. Approximately 3 weeks later I received a draft audit report detailing an extrapolated error amount of $137,993.63 based upon two (2) errors identified

in the report. After back and forth discussions with the audit department and resubmission of documentation the auditor was given during the audit but seemed to have overlooked, the final report indicated an overpayment of $6.59 based upon a keypunch error we had made on one prescription. The extrapolated fine for this claim was $2802 which is more than 425 times the actual price Medicaid paid for the prescription!

I have been more fortunate than many other pharmacy providers when navigating a Medicaid audit. I am aware of three Connecticut pharmacies that are facing fines greater than $100,000. These fines are due in part to findings indicating that some of the audited prescriptions were written on paper that only complied with *two of the three* elements required for the prescription blank to be considered tamper-proof!

The pharmacies have signed statements and/or medical records from the prescribers verifying that the prescriptions were in fact legitimate and were filled in accordance to their order but DSS refuses to accept this further documentation and insists that the pharmacist should have known they were written on improper paper. It is incomprehensible that a pharmacy can be fined $100,000 solely because it billed for legitimate prescriptions that were written on the wrong paper. This certainly does not constitute provider fraud yet but it certainly implies a consistent pattern of auditor disregard for Sec 17b-99 (2) of the state statues!

One of these pharmacy owner tells me his pharmacy is facing almost $145,000 in penalties based on clerical mistakes involving 3 prescriptions with a total value of $268 in payments received from the Medicaid program. This family owned pharmacy is struggling to find a way to pay this fine and remain in business.

As these examples demonstrate, the current Medicaid audit process routinely seeks to recover hundreds of thousands of dollars of legitimate payments made to pharmacies even when the correct drug is given to the correct patient for the correct price when no fraud has occurred. It is also disturbing that DSS maintains a no-negotiation policy that does not allow providers to provide any additional documentation after the fact to validate a prescription.

How can this unfair audit practice be rectified? The ability to extrapolate findings for claims under $1000 in value, over *all* of the paid claims encompassed by the audit sample time frame, provides DSS with the unintentional monetary incentive to recoup claims due to clerical, administrative or recordkeeping error. Extrapolation should only be allowed when clear-cut evidence is found and documented that a pattern of intentional fraud, waste and abuse has occurred. As with CMS rules for the Medicare Part D program, Medicaid should be required to correct the claim rather than recoup it when clerical, administrative or keypunch errors are found.

Raised Bill No. 5500 seeks to ensure that audits of providers who receive payments under the state Medicaid program are performed fairly and accurately. This legislation is necessary to ensure that provider audits return their focus to ferreting out fraud, waste and abuse while protecting all of Connecticut's Medicaid providers from excessive financial penalties based upon minor technicalities within the current audit guidelines operated by the Department of Social Services. In conclusion, I strongly urge you to support passage of Raised Bill No 5500 after including provisions to specify that extrapolation can only applied during Medicaid provider audits for cases of proven fraud, waste and abuse.

Thank you for your consideration of my views.